

Virtual Care and the Pandemic: Are We Reaching All Patients?

Faced with the rapid spread of a new, highly contagious virus, the Veterans Health Administration (VHA) was well positioned to provide virtual care at scale. The VHA's legacy in telehealth combined with newly enacted legislation easing the provision of services across state lines enabled the nation's largest integrated health care system to pivot quickly.

In their article, Baum and colleagues (1) document the VHA's experience by comparing the number of face-to-face appointments provided in 2016 to 2019 with the number provided during the initial 10 weeks of the coronavirus disease 2019 (COVID-19) pandemic. Their findings confirm a swift expansion of virtual care, including telephone and video visits, and a parallel decrease of in-person visits. Their research also adds to the body of literature on expansion of virtual care in the U.S. Department of Veterans Affairs (VA) and other organizations during the COVID-19 pandemic (2–4). On balance, the study found a decrease of 30% in 2020 appointments compared with 2016 to 2019. The authors note that these findings prompt important questions about the potential effect of delayed access to in-person care on patient-level outcomes.

Driven by the need to keep veterans (who are among the highest-risk groups for COVID-19) safe, minimize risk for those with nonacute medical needs, and conserve personal protective equipment, telehealth applications and virtual care proliferated, seemingly overnight. In addition to using standardized tools to identify those with complex needs and at highest risk (and proactively reach out to them), care teams at local VA facilities were aided by March 2020 guidance from national primary care and mental health leadership to prioritize these efforts. As the data show, virtual visits address, and will continue to address, the critically important need of providing essential health care while minimizing patient risk. However, lessons to be learned from virtual care transcend its use as a substitute for in-person visits.

For example, clinicians and all health professional trainees should come to regard virtual visits as an opportunity to further engage with patients and their families. Family members can participate in virtual visits from thousands of miles away, adding new dimensions (and information about the patient) to the appointment. Going forward, there is much to learn about using technology to enhance the dynamics of provider-patient communications instead of attempting to simply replicate in-person dynamics. How providers best communicate and engage with patients is different from face-to-face visits, and further information is needed to optimize the patient-provider relationship and experience (5).

Virtual visits also provide the opportunity to monitor chronic conditions; support wellness; and conduct virtual examinations, such as with an interactive virtual stethoscope. The VA is exploring these options across

primary care, mental health, specialty care, and other health professions. Moreover, to further support primary care teams, remote monitoring of patients with diabetes who are at increased risk for amputations and asynchronous advice via text messages to patients concerned about COVID-19 are also increasing. The VHA's strongest track record using telehealth relates to mental health care, for which there is a strong evidence base of effectiveness.

With 19.3% of Americans and 30% of veterans enrolled in the VHA living in rural areas (6, 7), the pandemic has heightened awareness of the need for state licensure waivers and technology upgrades for virtual care. Temporary waivers for state-specific licensure, such as those adopted by the Centers for Medicare & Medicaid Services and some states, should be granted permission to enable rapid augmentation of clinical capacity in highly affected areas. However, as seen from the current public health crisis, limitations associated with these waivers differ, resulting in an inconsistent landscape of laws (8). With regard to technology, the digital divide is narrowing, but the gap in connectivity in rural America and internet affordability remain challenges for many. Strategies to boost cellular signal and roll out 5G in the short term, coupled with cellular and broadband expansion efforts, are needed to provide every American the choice to receive care from home (9).

Overall, further investigation is needed to determine the optimal combination of virtual and in-person care for different clinical conditions and patient populations, especially for those with complex medical, social, and behavioral needs. In a recent quality improvement effort, a survey asked veterans about the modality of care they preferred, and 27% responded that they preferred video visits if clinically appropriate. As a learning health care system, the VHA is using such information to further evaluate and research potential strategies. In addition, the organization is collecting best practices to disseminate and scale throughout the system.

The rapid switch from in-person to virtual appointments across the VHA and most of U.S. health care is unprecedented, impressive, and here to stay. The COVID-19 pandemic has inextricably changed the way we think of care delivery, with rapid evolution of virtual care. We now have a unique opportunity to redefine postpandemic care with continued use of virtual care in the VA and other health systems. We must understand how best to integrate emerging virtual care tools (for example, vital sign monitoring from watches, products to augment the virtual visit physical examination, and home laboratory testing). To fully realize the potential of all these and emerging technologies, evidence is needed as to whom they benefit most. In addition, policymakers have signaled that virtual care is here to stay. Baum and colleagues have provided a critical starting

point for understanding how to optimize the virtual visit experience.

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